diabetes, prior vascular invention, dementia, and baseline functional status, we found "type of treatment" to be the most consistent independent predictor of outcome. While we acknowledge that our comparison does not represent the purity of a randomized prospective trial, we likewise believe it to be inappropriate to completely dismiss our valid statistical evidence.

Interestingly, our critics have chosen to quibble about our interpretation of the findings, taking a more optimistic, "glass half-full" not "glass half-empty" view toward the angioplasty cohort. Perhaps they are correct. But in the end, does it really matter? If quibbling is required to rationalize the superiority of revascularization over the gold standard of treatment failure (ie, limb amputation), then we all are truly "missing the forest for the trees". Perhaps we need to accept that sometimes outcome is influenced more by the deteriorating health of the patient than by the treatment modality employed.

In our financially failing health system where the rationing of care for the greater good is inevitable, we simply can not afford to devote endless resources for unproven therapies. In that light, if a patient is too chronically ill to realize the physical benefit of limb salvage, maybe it's time to "throw in the towel".

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Regarding "Bare metal stent infections: Case report and review of the literature"

We read with interest the report by Hogg et al[1] describing two case reports with bare metal stent infections and reviewing the literature. It is known that there are no standards for managing bare metal stent infections. Therefore, it is important that every new, uncommon, or difficult case is reported. Last year,[2] we reported an interesting case of stent infection by mucormycosis in a renal transplant patient, which was not included in the literature review by Hogg et al.[1]

Our report pointed out some interesting data regarding infectious complications following placement of bare metal stents in the external iliac artery. Indeed, it is the only report with fugal infection by mucormycosis, which has a predilection for vascular invasion causing thrombosis and infraction/tissue necrosis. This type of infection typically occurs in immunocompromised and diabetic patient. Interestingly, fugal infection by mucormycosis occurred while our patient was under prophylactic antibiotic therapy (vancomycin). The majority of reports regarding complications after percutaneous stenting involve the access site. Moreover, although in the majority of cases the symptoms were presented few days after the stent placement, in our case they were presented after 2 months in the form of septic microembolism. Notably, two novel risk factors for stent infections that can be suggested by our report are: the previous surgery in the artery in which the stent was placed and the immunocompromised patients. Finally, in our report the patient was treated by surgical stent resection, proximal-distal ligation of the infected external iliac artery, and femoral-femoral autologous vein by pass followed by intravenous therapy with amphotericin B for 3 months. One year later the patient was free from any symptoms and without recurrence of the mucormycosis.

In conclusion, we suggest that our report add new data regarding the above mentioned severe complication, and mucormycosis infection should be considered as a potential threat for bare metal stent insertion particularly in immunosuppressed patients.

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Reply

We appreciate the interest in our report and the comments provided by Drs Bellos, Moustardes, and Liapis regarding our review. The comments in their Letter to the Editor and the published case report by Liapis et al[1] regarding the importance of reporting cases of stent infections, antibiotic prophylaxis, and aggressive surgical and antibiotic therapy, mirror our own practice and sentiments. Over the past few years, we have been tracking stent infections that we have treated at our institution and found four total bare metal stent infections. Our published case report only includes two of these infections.[2] Of the unreported cases, one patient presented with a simultaneous prosthetic graft infection in addition to the bare metal stent infection, while the other patient presented with a concomitant infection of a prosthetic aortic endograft. Both of these cases were treated with resection, radical surgical debridement, and revascularization. We excluded these two reports from our publication because we believed it was impossible to determine which infection occurred first: the prosthetic graft material or the bare metal stent. Our intention was to publish a report highlighting cases of isolated bare metal stent infections.

When preparing our report, we read your publication with great interest.[1] However, similar to the cases we excluded, we believed your case was unique from the majority of the cases we included in our review. You described a patient that (1) had undergone previous arterial surgery within months of the peripheral artery stent deployment, (2) had recent treatment with antirejection therapy, and (3) had the possibility of an existing infection at the time of the stent deployment. For these reasons we felt your report, while very interesting and important, was distinctly different from the typical angioplasty and stent procedures we included in our review, as your patient had several known risk factors to develop a bare metal stent infection at the time of stent deployment.

However, your point about *mucormycosis* is important and worth reiterating. While reports exist of fungal infections in arterial grafts,[3] aortic endografts,[4] and covered stents,[5] your report [1] is the only one we identified with a fungal, not bacterial, bare metal stent infection. Given that no consensus has been reached regarding the optimal management of bare metal stent infections, our institution advocates prompt, radical debridement, and revascularization. But, your report makes a strong argument to consider the pathologic organism, specifically *mucormycosis*, when devising a treatment strategy. Several of the reports sited in our review did not treat patients with a surgical approach: four of these 11 patients died, two of these 11 appeared to have no adverse sequelae, and five had to be followed closely due to pseudoaneurysm formation or stent thrombosis.[2] Given the pathophysiology and virulence of